QME Exam Study Outline

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Thank you for your interest in becoming a Qualified Medical Evaluator (QME). QME's answer questions on important medical issues such as whether an injured worker is entitled to various benefits, needs more treatment, has a permanent impairment and disability, and is able to perform certain work activities.

The Physician's Guide to the Treatment of Injured Workers in California has served as a valuable reference for physicians for over a decade. However, the third edition was printed before the latest workers' compensation reforms and therefore certain concepts described in the guide have been superseded by the reforms. Although it may still serve as a background resource for your study to take the examination, you should also study the Labor Code and the recently updated QME regulations. Wherever there is a direct conflict between a statement in the Physician's Guide and the text of a current statute, regulation or this guide, you must consider the Physician's Guide to have been superseded. This guide, which primarily covers reform enacted under SB 899, will help you prepare for the upcoming QME test. This outline is not the definitive interpretation of all recently enacted legislation. The Labor Code is available on the internet at: http://www.leginfo.ca.gov/calaw.html . The current QME regulations are in Title 8 of the California Code of Regulations, and available at: http://www.dir.ca.gov/dwc/DWCPropRegs/qme_regulations/qme_regulations.htm SB 899, SB 228 and AB 749 can all be accessed on the internet at http://www.leginfo.ca.gov/bilinfo.html. SB 899 and SB 228 were passed in the 2003/2004 session, while AB 749 was passed in the 2002/2003 session. The DWC Medical Unit is beginning to revise the Physician's Guide and is hoping to publish a revised version during the next 12 months.

You need to know the legislation that is pertinent to treating and evaluating injured workers. You do not need to memorize the number of the section (e.g. Labor Code section 4600 or regulation 30), but rather learn about what the sections mean. This paper will point you to the general topics that the staff of the Division of Workers' Compensation thinks are important for you to understand.

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I. Date of Enactment of SB 899: Unless otherwise stated in a section of the Labor Code, SB 899 became effective April 19, 2004, and applies to all cases regardless of date of injury. It does not give a reason to reopen, rescind or change any existing order, decision or award that has already been issued by the Workers' Compensation Appeals Board (WCAB).

A. Individual Effective Dates by Issue:
(Most of these issues will be explained in more detail in other sections)

1. Treating physician presumption: repeal of the personal physician's or chiropractor's presumption of correctness 4/19/04

2. Supplemental job displacement benefits: Applies to injuries on or after 01/01/04.

3. QME Selection Procedures:
   Represented Cases with dates of injury on or after **1/1/2005**: New rules for selection of an AME or panel QME through the striking process.
   Represented Cases with dates of injury prior to 1/1/2005: If cannot agree on AME, each side selects own QME.
   Unrepresented cases (all dates of injury): QME must be obtained through QME panel process. Injured employee always has first right to file the panel request form, to specify the specialty of the QME and to select and schedule an appointment with one QME from the panel.

4. Mandatory medical treatment (up to $10,000), for treatment consistent with MTUS, until claims administrator accepts or denies the claim. (04/19/04).

5. Second spinal surgery opinion process (01/01/04).

6. The limitation of 24 physical therapy, 24 occupational therapy (added by SB 899) and 24 chiropractic visits per industrial injury is for injuries occurring on or after 01/01/04. Employer may authorize more in writing. (4/19/04) These cap limitations do <u>not</u> apply to visits for *postsurgical* physical medicine and postsurgical rehabilitation services that comply with MTUS (medical treatment utilization schedule approved by the AD). (1/1/09).

7. Medical provider networks can be used starting 01/01/05.

8. TD change in maximum number of weeks is for injuries after 04/19/04.

9. The AMA Guides were adopted into the Permanent Disability Schedule (PD Schedule) on 01/01/05. They are not used for all injuries however. For compensable claims arising before January 1, 2005, the AMA Guides apply to the determination of permanent disability when there has been either *no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability,* or when the employer is not required to provide the notice required by section 4061 to the injured worker. ***See quoted section Labor Code section 4660 on page 25. Also note that for injuries to the psyche, per the P.D. schedule adopted on 1/1/2005, use the GAF (global assessment of function) not the AMA guides. (1/1/05).**

10. Apportionment to causation became effective as of 04/19/04 and applies to all dates of injury if the claim is still has open issues.

B. Other effective dates:

1. American College of Occupational and Environmental Medicine (ACOEM) guidelines became the standard for medical treatment on 1/1/04, and effective 3/22/04, treatment consistent with ACOEM Practice Guidelines 2d edition (2004) carried the presumption of correctness for all dates of injury, whether settled or not. Effective **6/15/07**, the Administrative Director adopted the **Medical Treatment Utilization Schedule (MTUS)** which supplanted ACOEM as the guideline that carries the presumption of correctness. The MTUS was updated effective 7/18/2009. Changes included: 1) using ACOEM Practice Guidelines, 2d edition (2004) for all injuries except elbow injuries which uses the elbow chapter from ACOEM 2d edition (**2007**); 2) adding chronic pain medical treatment guidelines; and 3) postsurgical treatment guidelines.

2. Utilization review (UR): Effective 1/1/2004, all employers were required to have a UR program and effective 6/15/07 UR reviews must be based on the MTUS.

3. Effective 7/3/08, the California Supreme Court held in the *Sandhagen* case that the employer must use UR to resolve medical treatment requests, and may not instead object to treatment under Labor Code § 4062 in order to obtain an AME or QME report.

II. Apportionment:

There have been significant changes in apportionment because of SB 899. One change is that all reports that address permanent disability must contain a section on apportionment. If applicable, it is sufficient for the evaluator to state simply that there is no apportionment in a given case. Permanent disability is now based on causation and case law is being established to help interpret this section. An injured worker is required to disclose any previous permanent disability or physical impairment if asked to do so. Also, if an injured worker was given an award for a previous permanent disability, there is a presumption that the disability still exists. Unless an employee has one of the exceptions listed below in (E) 1, his or her disability rating cannot add up to over 100% over their lifetime for any region of the body. All evaluators, except licensed acupuncturists, are expected to be able to provide a medical opinion on apportionment.

A. Changes: Sections 4663 (previously addressed employer liability for aggravation of pre-existing disease), 4750 (previously addressed employer liability for combined disabilities), 4750.5 (previously prevented permanent disability awards that included disability caused by a subsequent noncompensable injury) are repealed. New sections 4663 (requiring the physician opinion on apportionment and apportionment based on causation) and 4664 (limiting employer liability to percentage of PD *directly caused* by industrial injury; applying the presumption of PD from all prior awards; limiting total PD to 100%) were adopted by SB 899 effective 4/19/04). You do not need to memorize these section numbers.

B. Same: Burden of proof on injury is on the injured worker. Burden of proof on apportionment is on the defendants.

C. Causation: (LC 4663 and 4664)

1. Apportionment of permanent disability shall be based on causation.

2. The employer shall only be liable for the percentage of permanent disability <u>directly caused</u> by the injury arising out of and occurring in the course of employment. The physician shall make an apportionment determination by finding what approximate percentage of the permanent disability was caused by the *direct result* of injury arising out of and occurring in the course of employment and what approximate percentage of the permanent disability was caused by other factors *both before and subsequent to* the industrial injury, including prior industrial injuries. Any physician who prepares a report addressing the issue of permanent disability due to a claimed industrial injury shall in that report address the issue of causation of the permanent disability.

3. For a physician's report to be considered complete **on the issue of permanent disability**, it must include an apportionment determination. The physician should **not** consider it a complexity factor for billing purposes unless there was an actual dispute about apportionment.

4. If the physician is unable to make an apportionment determination in his or her report, the physician shall state the specific reasons why the physician could not make a determination of the effect of that prior condition on the permanent disability arising from the injury. The physician shall then consult with other physicians or refer the employee to another physician from whom the employee is authorized to seek treatment or evaluation in accordance with this division in order to complete the apportionment section.

5. An employee who claims an industrial injury shall, upon request, disclose all previous permanent disabilities or physical impairments.

6. For an evaluator's opinion to be substantial evidence on apportionment, the medical opinion must disclose familiarity with the concepts of apportionment, describe in detail the exact nature of the apportionable disability, and set forth the basis for the opinion, so that the board can determine whether the physician is properly apportioning under correct legal principles.

D. Prior Award of PD: LC 4664(b)

If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury.

E. Accumulation of PD not to exceed 100% for one region of the body:

1. The ***accumulation of all*** permanent disability awards issued with respect to any one region of the body in favor of one individual employee shall not exceed 100 percent over the employee's lifetime unless the employee's injury or illness is conclusively presumed to be total in character pursuant to LC section 4662 (see below). The regions of the body are the following: hearing, vision, mental, behavioral disorders; the spine, the upper extremities, including the shoulders; the lower extremities, including the hip joints; the head, face, cardiovascular system, respiratory system, and all other systems or regions of the body not listed above.

The disabilities that are listed in section 4662 are:

a. Loss of both eyes or the sight in both eyes
b. Loss of both hands or the use of both hands
c. An injury resulting in practically total paralysis
d. An injury to the brain resulting in incurable mental incapacity (imbecility) or insanity

2. Also, the permanent disability rating for each individual injury sustained by an employee arising from the same industrial injury, when added together, cannot exceed 100 percent.

III. Treating Physician Presumption:

The Treating Physician Presumption, Labor Code 4062.9, repealed 4/19/04. The repeal of the personal physician's or chiropractor's presumption of correctness applies to all cases, regardless of the date of injury.

IV. The QME Process:

A. QME Selection Process:

1. **LC 139.2 (and related QME regulations) provide for the following**:

a. When requested by an employee or employer pursuant to LC section 4062.1 or 4062.2, the medical director shall randomly assign three-member panels of qualified medical evaluators.
b. The time frames within which medical evaluation reports shall be prepared and submitted by agreed medical evaluators (AMEs) and qualified medical evaluators (QMEs) shall be no more than 30 days after the evaluator has seen the employee or otherwise commenced the medical evaluation procedure.
c. An extension of the 30-day period, of not more than an additional 30 days, may occur in the following cases when the evaluator has not received test results or consulting physician's evaluation in time to meet the 30-day deadline. Also, the 30-day period may be extended by not more than 15 days when the failure to meet the 30-day deadline was for good cause. "Good cause" means any of the following: (1) medical emergencies of the evaluator or evaluator's family; (2) death in the evaluator's family; (3) natural disasters or other community catastrophes that interrupt the operation of the evaluator's business.
d. The evaluator must request approval from the Medical Director of DWC for an extension of time.

e. If a report is served after the 30-day period and the evaluator failed to obtain approval for an extension of time, either party may request a replacement QME and neither the employee nor the employer shall have any liability for payment for the medical evaluation report unless both the employee and the employer provide a written statement to the Medical Director agreeing to accept the late report.

2. **Unrepresented Track: Labor Code 4062.1**

The QME panel process for unrepresented employees has changed. The two parties are still not allowed to agree to an AME. The claims administrator is still responsible for giving the QME panel request form (QME Form 105) to the injured worker. The injured worker is the only one that can request a panel during the first 10 days after the claims administrator provides the form. Now, however, after the10 day period, if the injured worker does not request a panel, the claims administrator is allowed to make the panel request. The requesting party selects the specialty of the QME. Within 10 days of the issuance of the panel, the injured worker is supposed to select one physician from the panel of three and make an appointment. If the injured worker does not make an appointment, the claims administrator may select the physician and make the appointment. If the Medical Unit of DWC does not issue a panel naming 3 QMEs within 15 working days of receipt of the panel request in an unrepresented case, the employee shall have the right to obtain an evaluation from any QME.

a. The employer (or claims administrator) shall not seek agreement with an unrepresented employee on an agreed medical evaluator.
b. If either party requests a medical evaluation pursuant to LC sections 4060, 4061 or 4062, either party may submit the form prescribed by the administrative director for a panel of three qualified medical evaluators.
c. However, the employer may not submit the form unless the employee has not submitted the form within 10 days after the employer gave the form to the employee and requested the employee to submit the form.
d. The party submitting the request form shall designate the specialty of the physicians that will be assigned to the panel.
e. Within 10 days of the issuance of a panel of qualified medical evaluators, the employee shall select a physician from the panel to prepare a medical evaluation.

(1) The employee shall schedule the appointment.

(2) The employee shall inform the employer of the selection and the appointment.
(3) If the employee does not inform the employer of the selection within 10 days of the assignment of a panel of qualified medical evaluators, then the employer may select the physician from the panel to perform a medical evaluation.
(4) If the employee informs the employer of the selection within 10 days of the assignment of the panel but has not made the appointment, or if the employer selects the physician pursuant to this subdivision, then the employer shall arrange the appointment.

f. The evaluator shall give the employee, at the appointment, a brief opportunity to ask questions concerning the evaluation process and the evaluator's background.
g. The unrepresented employee shall then participate in the evaluation as requested by the evaluator unless the employee has good cause to discontinue the evaluation. For purposes of this subdivision, "good cause" shall include evidence that the evaluator is biased against the employee because of his or her race, sex, national origin, religion, or sexual preference or evidence that the evaluator has requested the employee to submit to an unnecessary medical examination or procedure.

(1) If the unrepresented employee declines to proceed with the evaluation, he or she shall have the right to a new panel of three qualified medical evaluators.

(2) If the appeals board subsequently determines that the employee did not have good cause to not proceed with the evaluation, the cost of the evaluation shall be deducted from any award the employee obtains.

h. If an employee has received a comprehensive medical-legal evaluation, and he or she later becomes represented by an attorney, he or she shall **not** be entitled to another evaluation (LC 4062.1).

3. **Represented track: Labor Code 4062.2**

Prior to SB 899 and now, for all represented cases with a date of injury before 1/1/2005, when a represented worker needed a QME evaluation, each party could select any QME after trying but failing to

agree to an AME. The two sides are still supposed to try to agree to an AME (who does not have to be a QME). If they are unable to agree to an AME within 10 days (20 if they agree to an extension), either side may ask for a QME panel once the party meets the statutory requirements. Once the panel is issued, the two sides have 10 days to try to agree to one QME from that panel to serve as an Agreed Panel QME. If they can't agree on one person, each party may eliminate one name from the list and the remaining QME does the evaluation. If the injured worker gets a QME evaluation under this section and later becomes unrepresented, the injured worker is not allowed to get another QME evaluation.

Requirements for a panel QME to be issued:

a. Whenever a comprehensive medical evaluation is ***required to resolve any dispute*** arising out of an injury or a claimed injury occurring on or after January 1, 2005, and the employee is represented by an attorney, the evaluation shall be obtained only as provided in this section.

b. Either party may commence the selection process for an agreed medical evaluator by making a written request that names at least one or more physicians to be the AME. This AME offer letter should also identify a disputed issue.

   (1) If no agreement is reached within 10 days of the first written proposal that names a proposed agreed medical evaluator, or any additional time not to exceed 20 days agreed to by the parties, either party may request the assignment of a three-member panel of qualified medical evaluators to conduct a comprehensive medical evaluation.

   (2) The party submitting the request shall designate the specialty of the medical evaluator, the specialty of the medical evaluator requested by the other party if it has been made known to the party submitting the request, and the specialty of the treating physician.

   (3) Within 10 days of assignment of the panel by the administrative director, the parties shall confer and attempt to agree upon an agreed medical evaluator (Agreed panel QME) selected from the panel.

   (4) If the parties have not agreed on a medical evaluator from the panel by the 10^{th} day after assignment of the panel, each party may then strike one name from the

panel. The remaining qualified medical evaluator shall serve as the medical evaluator.

(5) If a party fails to exercise the right to strike a name from the panel *within three working days of gaining the right to do so*, the other party may select any physician who remains on the panel to serve as the medical evaluator.
(6) Unlike an unrepresented case, if the Medical Director fails to issue a QME panel within 30 calendar days of receipt of the panel request, neither party has a right to select any QME to do the evaluation. Either party may seek an order from a judge that a panel be issued.

c. The represented employee shall be responsible for arranging the appointment for the examination, but upon his or her failure to inform the employer of the appointment within 10 days after the medical evaluator has been selected, the employer may arrange the appointment and notify the employee of the arrangements.

d. If an employee has received a comprehensive medical-legal evaluation from an AME or QME, and he or she later ceases to be represented, he or she shall not be entitled to an additional evaluation.

B. LC 4060 Disputes Over Compensability:

The procedure to obtain a medical-legal evaluation to determine compensability (whether the injury is covered by workers' compensation) has changed. Physicians who do these examinations are now selected through the panel process for unrepresented injured workers in Labor Code section 4062.1 and if the injured worker has an attorney, using the procedure in Labor Code section 4062.2. If the injured worker is not represented, the claims administrator must either tell the worker that they *request* an examination to determine compensability or must send the worker a notice the claim is denied and the injured worker *may* request a QME for this purpose. In either case, the injured worker has a right to request an evaluation, and the injured worker always has the first right to submit the QME request form and to specify the specialty of the QME panel. Once the claims administrator has accepted any body part, neither party may request a QME panel on compensability because LC section 4060 no longer applies after the *claim* has been accepted by the acceptance of any body part.

1. This section covers disputes over the compensability of any injury. This does not apply where injury to any body part or parts is accepted as compensable by the employer.

2. The employer/employee shall not be liable for any comprehensive medical-legal evaluation performed by other than the treating physician, except as provided in this section. Reports of treating physicians shall be admissible.

3. If a medical evaluation is required to determine compensability at any time after the filing of the claim form, and the employee is represented by an attorney, follow the procedure provided in LC section 4062.2.

4. If a medical evaluation is required to determine compensability at any time after the claim form is filed, and the employee is not represented by an attorney, the employer shall provide the employee with notice either that the employer requests a comprehensive medical evaluation or that the employer has not accepted liability and the employee may request a comprehensive medical evaluation to determine compensability per Labor Code section 4062.1.

5. If the injured worker is represented, either party may request a comprehensive medical evaluation to determine compensability. The evaluation shall be obtained only by the procedure provided in LC section 4062.2.

C. LC 4061 Permanent Disability Disputes:

This section is used to settle a dispute over the permanent disability described by the treating physician or that physician's determination that there is no permanent disability. If the injured worker has an attorney, they use the process found in Labor Code section 4062.2. If the worker is not represented, either the injured worker or the claims administrator may ask for a panel usingthe procedure found in section 4062.1.

1. If the parties do not agree to a permanent disability rating based on the treating physician's evaluation, and the employee is represented by an attorney, a medical evaluation to determine permanent disability shall be obtained as provided in LC section 4062.2.

2. If the parties do not agree to a permanent disability rating based on the treating physician's evaluation, and the employee is not represented by an attorney, the employer shall immediately provide the employee with a form prescribed by the medical director with which to request assignment of a panel of three qualified medical evaluators. Either party may request a comprehensive medical evaluation to determine

permanent disability, and the evaluation shall be obtained only by the procedure provided in LC section 4062.1.

a. The qualified medical evaluator who has evaluated an unrepresented employee shall serve the comprehensive medical evaluation, the QME Findings Summary Form (QME Form 111), the Employee Disability Questionnaire (DWC-AD 100 (DEU)) and the Request for Summary Rating Determination (DWC-AD 101 (DEU)) with the QME Declaration of Service form (QME Form 122) on the employee, employer, and the Disability Evaluation Unit, within 30 days of the initial evaluation.

b. The unrepresented employee or the employer may submit the treating physician's permanent and stationary report (DWC form PR-4) to the DEU for the calculation of a permanent disability rating.

c. Within 20 days of receipt of the comprehensive medical evaluation, the administrative director shall calculate the permanent disability rating according to LC section 4660 and serve the rating on the employee and employer.

d. Any comprehensive medical evaluation concerning an unrepresented employee which indicates that there is apportionment shall first be submitted by the AD to a workers' compensation judge who may refer the report back to the QME for correction or clarification if the judge determines the proposed apportionment is inconsistent with the law.

e. If the AD finds the comprehensive medical evaluation is not complete or not in compliance with the required procedures, the AD shall return the report to the treating physician or QME for appropriate corrections.

3. With the exception of an evaluation or evaluations prepared by the treating physician or physicians, no evaluation of permanent impairment and limitations resulting from the injury shall be obtained, except in accordance with LC section 4062.1 or 4062.2. Evaluations obtained in violation of this prohibition shall not be admissible in any proceeding before the appeals board.

D. Use LC 4062(a) for all other medical disputes not covered by LC 4060 and 4061:

Any other dispute over an opinion by the treating physician on a benefit issue that is not covered by the previous sections (LC 4060 or 4061) falls under this section (LC 4062). An example is a dispute about treatment. It is very important to note the timeframes as the parties lose their right to this process if they don't start the process within the timeframe. For instance, if the treating physician writes that the injured worker needs a specific treatment, the claims administrator must use the utilization review process (in Labor Code section 4610 and 8 CCR 9792.6 *et seq*) to approve, deny, delay or modify the request. If the request is denied, delayed or modified by a reviewing physician under the UR procedures in a timely manner and claims administrator (or URO) sends a notice of the denial/delay/modification to the injured worker, the employee has 20 days [or 30 days if not represented] from receiving that notice to object in writing in order to start the AME/QME process under LC 4062. Note, however, that the California Supreme Court held on 7/3/2008 in *SCIF v WCAB (Sandhagen)* that the employer's only remedy to dispute a treating physician's recommendation for treatment is to use the UR process. The employer (or claims administrator) may not bypass UR and simply object under LC 4062 in order to start the AME/QME process.

1. If either the employee or employer objects to a medical determination made by the treating physician concerning any medical issues **not covered** by LC section 4061 or 4062 **and not subject to** LC section 4610[utilization review], the objecting party shall notify the other party in writing of the objection within 20 days of receipt of the report if the employee is represented by an attorney or within 30 days of receipt of the report if the employee is not represented by an attorney. (emphasis added)

2. If the employee objects to a decision made pursuant to LC section 4610 to modify, delay, or deny a treatment recommendation (i.e. a utilization review decision), the employee shall notify the employer of the objection in writing within 20 days of receipt of that decision. These time limits may be extended for good cause or by mutual agreement.

    a. If the employee is represented by an attorney, a medical evaluation to determine the disputed medical issue shall be obtained as provided in LC section 4062.2, and no other medical evaluation shall be obtained.

    b. If the employee is not represented by an attorney, the employer shall immediately provide the employee with a form prescribed by the medical director with which to request

assignment of a panel of three qualified medical evaluators, the evaluation shall be obtained as provided in LC section 4062.1, and no other medical evaluation shall be obtained.

If either the employer (claims administrator) or the employee disputes any other opinion of the treating physician (e.g. whether the injury is permanent and stationary, whether the injured worker needs future medical treatment, whether the injured worker has new and further disability, whether the need for treatment for another or new body part was caused by the claimed injury), either party may object to that medical determination by the treating physician by notifying the other party in writing within 20 days of receipt of the treating physician's report (in represented cases) or within 30 days of receipt of the treating physician's report (in unrepresented cases) and by following the procedures under LC 4062.1 or 4062.2 to obtain a comprehensive medical/legal evaluation report (LC 4062(a)).

E. LC 4062(b) Spinal Surgery Dispute Procedure:

A dispute about spinal surgery is evaluated by means of a special process described in Labor Code 4062(b), not by the typical QME or AME selection process. If the employer disagrees with the treating physician's recommendation that the worker needs spinal surgery, the claims administrator has 10 calendar days from the receipt of the report to complete UR and to object by filing a form with the DWC Medical Unit. If the worker is represented, the two attorneys can agree to a board-certified or board-eligible orthopedic surgeon or neurosurgeon. If they can't agree or if the injured worker does not have an attorney, the spinal surgery second opinion procedure (SSSO) must be used. The Administrative Director has a list of eligible surgeons and the AD selects one randomly to give the opinion. The assigned surgeon is not supposed to have any conflict of interests for that particular case. If the spinal surgeon says that the injured worker needs surgery, the insurer must provide the surgery. If the assigned surgeon says the spinal surgery is not necessary, the employer must file a declaration of readiness at the WCAB court which will lead to review of the issue and the medical records by a workers' compensation administrative law judge.

1. Employer objections to the treating physician's recommendation for spinal surgery shall be subject to the following procedure:

    a. The employer may object to a report of the treating physician recommending that spinal surgery within 10 days of the receipt of the report.

        (1) If the employee is represented by an attorney, the parties shall seek agreement with the other party on a California licensed board-certified or board-eligible orthopedic surgeon or neurosurgeon to prepare a

second opinion report resolving the disputed surgical recommendation.

(2) If no agreement is reached within 10 days, or if the employee is not represented by an attorney, an orthopedic surgeon or neurosurgeon shall be randomly selected by the AD to prepare a second opinion report resolving the disputed surgical recommendation

b. The second opinion report shall be served on the parties within 45 days of receipt of the treating physician's report.

c. If the second opinion recommends surgery, the employer shall authorize the surgery.

d. If the second opinion report does not recommend surgery, the employer shall file a declaration of readiness to proceed (to court).

F. LC 4062.3 Communication:

This section tells the parties how to send information to a QME or an AME and forbids the QME and AME from engaging in *ex parte* communication. Following these procedures, especially serving (sending) the information on the opposing parties, prevents *ex parte* communication (see below). It is important for a QME to know the rules because the other party could decide not to use the QME's report if the rules are not followed.

1. Any party may provide to the qualified medical evaluator selected from a panel any of the following information:

    a. Records prepared or maintained by the employee's treating physician or physicians.

    b. Medical and non-medical records relevant to determination of the medical issue.

2. QME: Information that a party proposes to provide to the qualified medical evaluator selected from a panel should be served on the opposing party 20 days before the information is provided to the evaluator. If the opposing party objects to sending non-medical records (such as a video tape) within 10 days thereafter, the records shall not be provided to the evaluator. Either party may take the issue to court to establish the accuracy or authenticity of non-medical records prior to the evaluation.

3. AME: If an agreed medical evaluator is selected, as part of their agreement on an evaluator, the parties must agree on what information is to be provided to the agreed medical evaluator.

4. In any formal medical evaluation, the agreed or qualified medical evaluator shall identify the following in the report:

    a. All information received from the parties.
    b. All information reviewed in preparation of the report.
    c. All information relied upon in the formation of his or her opinion.

5. **All** communications with an **AME or a QME** selected from a panel before a medical evaluation **shall be in writing** and shall be served on the opposing party 20 days in advance of the evaluation. **Any subsequent communication** with the medical evaluator **shall be in writing and shall be served** on the opposing party when sent to the medical evaluator. In other words, they should send the letter not only to the AME/QME, but also to the other party. (emphasis added)

G. Ex Parte Communication with an AME or a QME selected from a panel is prohibited.

1. If a party communicates with the AME or the QME in violation of subdivision 4062.3(e)(which requires all communication to be written), the aggrieved party may elect to terminate the medical evaluation and seek a new evaluation from a QME to be selected according to LC section 4062.1 or 4062.2, as applicable, or proceed with the initial evaluation.

2. The party making the communication prohibited by this section shall be subject to being charged with contempt before the appeals board and shall be liable for the costs incurred by the wronged party as a result of the prohibited communication.

3. This restriction shall not apply to oral or written communications by the employee or, if the employee is deceased, the employee's dependent, in the course of the examination or at the request of the evaluator in connection with the examination.

4. Upon completing a determination of the disputed medical issue, the medical evaluator shall summarize the medical findings on a form prescribed by the AD and serve the formal medical evaluation and the summary form on the employee and the employer.

H. LC 4062.3 Scope of Medical Evaluations and New Evaluations:

1. The medical evaluation shall address all contested medical issues arising from all injuries reported on one or more claim forms prior to the date of the employee's initial appointment with the medical evaluator.
2. If, after a medical evaluation is prepared, the employer or the employee subsequently objects to any new medical issue, the parties, to the extent possible, shall utilize the same medical evaluator who prepared the previous evaluation to resolve the medical dispute.

I. LC 4062.5 Report Time Frames:

1. If a QME selected from a panel fails to complete the formal medical evaluation within 30 days of initiating the evaluation and fails to obtain an extension of time from the DWC Medical Director, a new evaluator may be obtained upon the request of either party, as provided in LC sections 4062.1 or 4062.2. The Medical Director may grant an extension of time for an additional 30 days. An extension of 15 days may be granted for medical emergencies of the evaluator or his/her family, death in the evaluator's family or natural disasters or other community catastrophes that interrupted business.
2. Neither the employee nor the employer has to pay for the formal medical evaluation which was not completed within the required deadline, unless the employee or employer, on forms prescribed by the administrative director, <u>each</u> waive the right to a new evaluation and elect to accept the original evaluation even though it was not completed within the required time frames.

V. Evaluator's Opinions as Substantial Evidence

Physicians, both treating physicians and evaluators such as AMEs and QMEs, provide expert opinions used to determine benefits and resolve disputed medical issues. As an expert witness, the opinion must be based on the physician's *judgment, experience, training, and skill*, as well as the standards below.

An award of benefits, including medical treatment and indemnity (temporary and permanent), must be based on substantial evidence. For a physician's opinion to be substantial evidence on a disputed issue that needs a medical determination, including medical causation, treatment and disability, the physician's opinion must be based on *reasonable medical probability*.

The opinion is not substantial evidence if it is based on an incorrect medical history, facts no longer germane, on inadequate medical histories or

examinations, on incorrect legal theories, or on surmise, speculation, conjecture or guess. To be substantial evidence, an evaluator's report must set forth the reasoning behind the physician's opinion, not merely his or her conclusions.

VI. Medical Utilization and Medical Treatment (MTUS):

A. Treatment after notice of injury by claim form and before claim rejected or accepted:

A new rule was added effective 4/19/04 that covers initial treatment before the claims administrator decides whether a claim is accepted (work related). The claims administrator still has 90 days to make this decision. While the claims administrator is deciding whether to accept or deny the claim, the claims administrator must provide and pay for medical treatment up to $10,000 that is consistent with the MTUS (medical treatment utilization schedule). Just because a claims administrator pays for treatment during this period does not mean that the insurer has accepted the claim. Requests for treatment during this period are subject to utilization review. Also, effective 1/1/2010, an employer must pay for treatment that is authorized and may not rescind or modify the authorization except, when the treatment authorized is a series of treatments, authorization for those treatments in the series not already provided may be rescinded or modified.

LC 5402 provides that within one working day after an employee files a claim form under LC section 5401, the employer shall authorize the provision of all treatment, consistent with the MTUS (treatment guidelines), for the alleged injury and shall continue to provide the treatment until the date that liability for the claim is accepted or rejected. Liability for medical treatment shall be limited to ten thousand dollars ($10,000.00). Treatment provided in this provision does not give rise to a presumption of liability on the part of the employer.

B. Medical Treatment Utilization Schedule (MTUS):

In the past, the treating physician's opinion was given the presumption of correctness for medical issues. Now, the MTUS is given this presumption. If something is not covered by the MTUS, treatment should be in accordance with other evidence-based, scientific treatment guidelines that are recognized by the national medical community. The claims administrator or the injured worker can challenge ("rebut") the MTUS using scientific evidence, as seen below. If you are writing about a treatment issue in a medical-legal evaluation, refer to the MTUS and discuss whether or not the in dispute in the case treatment is consistent with this guideline. If the treatment recommended is not consistent with the guidelines or is not in the guideline, cite another evidence-based, medical treatment guideline(s) generally recognized by the national

medical community and that are scientifically based. Currently, the MTUS is based on the American College of Occupational and Environmental Medicine (ACOEM) Practice Guidelines (2nd edition) with a supplement on acupuncture. New sections of the MTUS on chronic pain and post surgical treatments were added effective July 18, 2009. The guideline is going to be updated regularly.

1. The injured worker is entitled to medical treatment that is reasonably required to cure or relieve the injured worker from the effects of his or her injury. Medical treatment that is reasonably required to cure and relieve means treatment that is based upon the guidelines adopted by the administrative director pursuant to LC section 5307.27 (MTUS).

2. For all injuries not covered by the MTUS, authorized treatment shall be in accordance with other evidence based medical treatment guidelines generally recognized by the national medical community and that are scientifically based.

3. Beginning March 22, 2004 and until June 15, 2007, the ACOEM guidelines were presumptively correct on the issue of extent and scope of medical treatment until the AD the MTUS. The MTUS was amended effective 7/18/2009, to add sections addressing chronic pain and post-surgical treatment.

4. The recommended guidelines are evidence- and scientifically-based, nationally recognized, and peer-reviewed.

5. The presumption is rebuttable and may be overcome by a preponderance of the scientific medical evidence establishing that a variance from the guidelines is reasonably required to cure or relieve the injured worker from the effects of his or her injury.

6. LC section 4600 provides medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve the injured worker from the effects of his or her injury shall be provided by the employer. 'Reasonably required to cure or relieve from the effects of injury means treatment that is based on guidelines adopted by the AD as the MTUS.

C. Limitation of Physical Therapy, Occupational Therapy and Chiropractic:
No matter what the treatment guidelines state, if a worker was injured <u>on or after 1/1/04</u>, the worker is entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits for that injury <u>except</u>

where post surgical physical medicine or rehabilitation services is warranted. The claims administrator can agree in writing at any time to more sessions on any given case.

1. LC section 4604.5(d)(1) Notwithstanding the MTUS, for injuries occurring on and after January 1, 2004, an employee shall be entitled to no more than 24 chiropractic, 24 occupational therapy, and 24 physical therapy visits per industrial injury.

2. Adjusters can authorize additional treatment without waiving the section.

D. Medical Control: (No Medical Provider Network)

The rules about control of the care of an injured worker have changed. The biggest change is the formation of medical provider networks (MPNs). However, there have also been changes to the rules on predesignating a physician, which are listed below.

1. Unless the employer or the employer's insurer has established a medical provider network (MPN) as provided for in LC section 4616, after 30 days from the date the injury is reported, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area.

2. Predesignation: The employee has a right to be treated by a predesignated personal physician from the date of injury if all of the following requirements have been meet:

   a. If an employee has notified his or her employer in writing prior to the date of injury that he or she has a personal physician to be used for treatment of work injuries.

   b. If the employer provides non-occupational group health coverage (even if the employee is not enrolled) and the physician is within a reasonable geographic area.

   c. For purposes of this section a personal physician shall meet all of the following conditions. The physician is (i) the employee's regular physician and surgeon, licensed pursuant to the Business and Professions Code; (ii) the physician is the employee's primary care physician and has previously directed the medical treatment of the employee, and who retains the employee's medical records, including his or her medical history; (iii) and the physician agrees to be predesignated.

d. The insurer may require prior authorization of any non-emergency treatment or diagnostic service and may conduct reasonably necessary utilization review pursuant to LC section 4610.

e. This subdivision shall remain in effect only until December 31, 2009, and as of that date is repealed, unless a later enacted statute, that is enacted before December 31, 2009, deletes or extends that date.

E. Medical Provider Networks:

Employers or insurers can establish medical provider networks as of 1/1/05. The employer or insurer with an MPN 'controls the treatment' for the life of the claim of an injured worker who is in a medical provider network (MPN), unless the employer or insurer violates MPN rules relating to timely and proper notice or continuity of care. The injured worker can change physicians in the MPN. The injured worker can also ask for a second and third opinion if the worker disagrees with the doctor concerning a diagnosis, diagnostic procedure or treatment.

LC section 4616(a) (1) provides that on or after January 1, 2005, an insurer or employer may establish or modify a medical provider network (MPN) for the provision of medical treatment to injured employees. The network shall include physicians primarily engaged in the treatment of occupational injuries and physicians primarily engaged in the treatment of non-occupational injuries.

a. To the extent feasible, all medical treatment for injuries shall be readily accessible to all employees.

b. If the employer or insurer meets the requirements of this section, the AD may not withhold approval or disapprove an employer's or insurer's medical provider network based solely on the selection of providers. In developing MPN an employer or insurer shall have the exclusive right to determine the members (e.g. physicians) of their network.

c. Medical provider networks will be composed of physicians that are both primarily occupational and primarily non-occupational, with a goal of 25% primarily non-occupational. Networks shall include sufficient number and types of physicians to provide timely treatment, and physician compensation shall not be structured to achieve goals of reducing, delaying or denying treatment.

d. All treatment provided shall be provided in accordance with the medical treatment utilization schedule established pursuant to LC section 5307.27.

e. Treatment by a specialist who is not a member of MPN may be permitted on a case-by-case basis if the medical provider network does not contain a physician who can provide the approved treatment and the treatment is approved by the employer or the insurer.

f. If an injured employee disputes either the diagnosis or the treatment prescribed by the treating physician, the employee may seek the opinion of another physician in the MPN.

g. If the injured employee disputes the diagnosis or treatment prescribed by the second physician, the employee may seek the opinion of a third physician in the MPN.

F. Independent Medical Review:

If an employee has seen the third physician for an opinion in the MPN and still disputes the diagnosis, diagnostic service, or treatment prescribed by the treating physician, the employee may request independent medical review (IMR). Independent medical reviews do not cover issues such as disability status, apportionment, or causation. The Administrative Director has contracts with physicians across California to give an independent medical review opinion on these diagnosis and treatment disputes. If the reviewer agrees with the injured worker, the worker can get that treatment or diagnostic procedure within or outside the MPN. Remember that an injured worker can change physicians in an MPN, so there is usually no need to obtain an IMR.

1. The AD shall contract with individual physicians or an IMR organization to perform independent medical reviews.

2. Only California-licensed Medical Doctors, Osteopaths or Podiatrists, who are board certified can be IMR's.

3. The injured worker decides whether the evaluation will be in-person or a record review only.

4. The reviewer may order any diagnostic tests necessary to make the decision about the medical treatment. The reviewer determines whether the disputed health care service was consistent with the MTUS based on the specific medical needs of the injured employee.

G. Utilization Review:

All employers must have a utilization review (UR) program that complies with the LC and a UR plan that is filed with the Administrative Director. A

claims administrator may file a letter identifying its URO in lieu of filing a UR plan. When a treating physician asks to do a diagnostic procedure or treatment, a non-physician claims examiner or nurse can approve that request within a certain timeframe. However, only a physician (M.D., D.O., D.C., D.P.M, psychologist, licensed acupuncturist or optometrist) reviewer, acting within the scope of his/her licensure and clinical competence, can delay, deny, or modify a request. They need to send the basis (e.g. relevant excerpt of the MTUS or other guideline relied upon) with the clinical reasons for their decision to the injured worker and the treating physician. The physician reviewer's name and hours of availability must also be given to the treating physician along with a way to contact the reviewer.

1. Utilization review (UR) means utilization review or utilization management functions that prospectively, retrospectively, or concurrently review and approve, modify, delay, or deny, treatment based whole or in part on medical necessity to cure and relieve, treatment recommendations by physicians.

2. Every employer shall establish a UR process in compliance with LC 4610 either directly or through its insurer.

3. The employer can request additional information from the physician in order to determine if treatment should be approved, modified or denied. The employer can only ask for information reasonably necessary to make a determination.

4. **Time limits** – Making the decision: Within 5 *business* days of receipt of a request for authorization (RFA) from a physician who is treating an injured worker, the claims administrator or URO must ask for additional reasonable information needed to make the decision, or approve, deny or modify the request. If the requested reasonable information has not been received, by the 14th *calendar* day after receipt of the RFA, the physician reviewer must either deny the RFA with the stated condition that it will be reconsidered upon receipt of the information, or may decide to 'delay' the decision until the requested information is received. Once the requested information has been received after such a delay, the decision to approve, modify or deny must be made and communicated within 5 business days. Only in the case of spinal surgery requests, both the UR decision and an employer objection to the spinal surgery must be completed within 10 calendar days of receipt of the treating physician's report.

5. Request for authorization (RFA) means written confirmation of an oral request or a written request for a specific course of proposed medical treatment, that is set forth on: a) a Doctor's First Report form (DLSR

5021); b) the Primary Treating Physician's Progress Report form (DWC form PR-2); or in narrative form *containing the same information required in the PR-2* and the narrative must be clearly marked at the top 'request for authorization'.

6. Authority to decide: Both physicians and non-physicians may approve a requested treatment. A decision to deny, delay or modify treatment can only be made by a physician within the scope of his or her license, not the adjuster or UR nurse case manager. No person other than a licensed physician who is competent to evaluate the specific clinical services, and where the services are within the scope of the physician's practice may modify, delay or deny requests for authorization for medical treatment. However, as mentioned above, within the first 5 business days, a non-physician may request additional information needed to make the decision on the RFA. But by the 14th calendar day after receipt of the request for authorization, only a physician may decide to delay, modify or deny the requested treatment.

7. Manner of announcing decision: The decision must be communicated to the requesting physician by telephone or fax within 24 hours of making decision. If the decision is first communicated by phone, a written decision meeting the regulatory content and distribution standards must be issued within 24 hours (for concurrent UR) or within 2 business days (for prospective UR) or within 30 calendar days (for retrospective UR).

8. Content: The decision to deny, delay or modify an RFA must describe: the date of decision; the treatment requested; describe any treatment approved; for the treatment denied, delayed or modified, the decision must give a clear, concise explanation of the reasons for decision; describe the medical criteria or guidelines used to make the decision; the clinical reasons relating to medical necessity; a statement advising the injured worker of the dispute rights under LC 4062 (to trigger the AME/QME process); mandatory language regarding obtaining an attorney or contacting an Information and Assistance office; if applicable, how any internal, voluntary UR appeal process may be pursued concurrently with the LC 4062 dispute process; and the name, specialty and hours of availability of the physician reviewer.

9. If UR results in a denial, delay or modification of the treating physician's recommended treatment and the employee disputes the decision, the dispute will be resolved by the use of LC section 4062 (the AME/QME process).

10. The employer's (or claims administrator's) **only** remedy for resolving requests for authorization of medical treatment is to use utilization review. The employer (or claims administrator) may not simply object

to recommended treatment under LC 4062 and start the AME/QME process. (*Sandhagen).*

11. Spinal surgery requests: When the treating physician recommends spinal surgery, the employer must complete the UR review and, if applicable, file a DWC form 233 with the AD to object to the recommended surgery. Both must be completed within 10 calendar days of receipt of the treating physician's report. Therefore the general UR timeline (14 calendar days and delay decision extending time) beyond the 10th calendar day do not apply and the UR decision may not be delayed indefinitely.

VII: Temporary Disability LC 4656

Except for a few conditions, temporary disability is now limited to 104 weeks as seen below:

A. Aggregate disability payments for a single injury occurring on or after 4/19/04, causing temporary disability shall not extend for more than 104 compensable weeks within a period of two years from the date of commencement of temporary disability payment. For dates of injury before 4/19/04, check Labor Code section 4656.

B. For a single injury occurring on or after 1/1/2008, aggregate TD payments are limited to 104 weeks within a period of FIVE years from the date of injury.

C. Notwithstanding paragraphs A and B above, for an employee who suffers from the *following injuries or conditions*, aggregate disability payments for a single injury occurring on or after 4/19/04, causing temporary disability shall not extend for more than 240 compensable weeks within a period of five years from the date of the injury: *Acute and chronic hepatitis B., acute and chronic hepatitis C, amputations, severe burns, human immunodeficiency virus (HIV), high-velocity eye injuries, chemical burns to the eyes, pulmonary fibrosis and chronic lung disease.*

VIII. Permanent Disability

California has had a unique method to determine disability for decades. Most states have based the evaluation of disability on the American Medical Association's Guides to the Evaluation of Permanent Impairment. California adopted these guides starting on January 1, 2005 to implement a more objective process. Physicians will now measure ***impairment*** by using The American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment

(5th Edition) for both description and percentages. A rater will change the impairment rating into a disability rating by adjusting for future earnings capacity, age and occupation.

The Labor Code § 4660 states:

> **A new permanent disability (PD) schedule is to be adopted by 01-01-05. For compensable claims arising before January 1, 2005, the revised schedule shall apply to the determination of permanent disability when there has been either no comprehensive medical-legal report or no report by a treating physician indicating the existence of permanent disability, or when the employer is not required to provide the notice sent to the injured worker with the last payment of temporary disability indemnity, as required by Labor Code section 4061.**

Not all injured workers who are evaluated after January 1, 2005 will have reports based on the AMA Guides. For instance, if an injured worker had a permanent and stationary report describing permanent disability completed prior to January 1, 2005, any subsequent report would use the old permanent disability schedule (adopted in 1997), not the permanent disability schedule adopted effective 1/1/2005 that is based on the AMA Guides. If that worker did not have a permanent and stationary report done before 2005 and the insurer did not have to give notice that there was going to be permanent disability prior to 2005, the worker's reports would be written using the AMA Guides. If a worker is injured on or after January 1, 2005, that worker will have any impairment rating done using the AMA Guides. Look at Labor Code section 4660(d) or the Schedule of Permanent Disabilities adopted effective 1/1/2005, for the exact wording.

You are expected to know the basic principles of the AMA Guides.

The Administrative Director has enacted regulations that state that up to an additional 3% WPI impairment rating can be given to an injured worker in certain circumstances for pain. A whole person impairment rating based on the body or organ rating system of the AMA Guides may be increased by up to 3% WPI if the burden of the worker's condition has been increased by pain-related impairment in excess of the pain component already incorporated in the standard WPI rating for that body part or organ. Chapter 18 of the AMA Guides will help you understand when you can give this extra rating. In most circumstances, the additional rating for pain should not be necessary as the usual impairment ratings already provide for a normal amount of pain for any given injury. You cannot add this 1 to 3% unless there was a ratable impairment. So, if the injured worker had an injury that was rated at 0% under the AMA Guides, even though he has pain, you cannot add the extra one to three percent. Although you will not be tested on producing a permanent disability rating formula, it is important to know what a rating looks like and what its component parts are.

A. Physician's opinion on permanent disability:

The evaluating physician is expected to provide an opinion regarding the injured worker's permanent impairment and disability. When determining the injured worker's whole person impairment using the AMA Guides, the physician "…may utilize any chapter, table, or method in the AMA guides that most accurately reflects the IW's impairment." (Almaraz v. Environmental Recovery Services/SCIF [2009] 74 Cal. Comp. Cas 1084 [en banc]). "….the physician may not use any chapter, table or method in the AMA Guides simply to achieve a desired result, e.g. a WPI that would result in a PD rating based directly or indirectly on any Schedule in effect prior to 2005…..the opinion must set forth the facts and reasoning which justify it…..a physician's WPI opinion that is not based on the AMA Guides does not constitute substantial evidence." All the WPI medical evidence, including rebuttal evidence, must be based on an opinion applying criteria within the four corners of the AMA Guides.

Therefore, based on the physician's judgment, experience, training, and skill, the reporting physician must provide an expert opinion on the injured employee's WPI using *any* chapter, table, or method of assessing impairment within the four corners of the AMA Guides that most accurately describes the employee's impairment and the opinion must include the reasoning for the opinion.

To rebut another physician's opinion about permanent disability (e.g. the opinion of the primary treating physician), the rebuttal medical opinion must meet this same standard. If the dispute is litigated, the Workers' Compensation Administrative Law Judge must determine which opinion is substantial evidence and which is more persuasive.

Components of rating formula: Per Labor Code section 4660(a), permanent disability is determined by taking account of the nature of the physical injury or disfigurement, the occupation, the age at the time of injury and the employee's diminished future earning capacity (DFEC). A rating formula under the 2005 Permanent Disability (PD) rating schedule consists of: 1) the impairment number from the AMA Guides; 2) the standard impairment rating expressed as WPI (whole person impairment); 3) impairment rating number after apply earning capacity adjustment based on FEC rank [from the AD's PD schedule]; 4) occupational adjustment (occupation group from PD schedule and occupational variant letter from PD schedule); and 5) age adjustment. "FEC" means future earning capacity. For example, in the case of a 29 year old maintenance electrician with a knee injury:

17.05.04.00 – 14 – [2]16 – 380I – 22 – 20

17.05.XX.XX is a knee impairment as described in chapter 17 of the AMA Guides, and the remaining digits (XX.05.04.00) are found in the PD schedule under impairment number to identify a knee with impairment of range of motion (17.05.04.00).
14 is the WPI (whole person) standard impairment rating.
[2] is the FEC rank (found in PD schedule) for this impairment
16 is the impairment rating after adjustment by the FEC rank
380 is the occupational group for this occupation (found in the PD schedule)
I is the variant letter for the injured body part for this occupation (found in the PD schedule)
22 is the Standard Rating Percent after applying the Occupational Adjustment Table in the PD schedule
20 is the adjusted Rating Percent after applying the table that adjusts based on the age of the injured employee at the time of injury (table in the PD schedule).

IX. Job Displacement Benefits/Vocational Rehabilitation:

The benefits that an injured worker receives, with regards to job displacement benefits or vocational rehabilitation, depends on the date of injury. Physicians will have a role in determining eligibility for injuries that occurred before 1/1/04 but not for injuries after that date.

A. Vocational Rehabilitation: LC section 139.5 was reinstated to provide for a vocational rehabilitation unit and the payment of vocational rehabilitation benefits only for injuries before 01-01-04. The section reestablished the $16,000.00 cap and allowed the settlement of vocational rehabilitation. This section only applied to injuries occurring before January 1, 2004 and **remained in effect only until January 1, 2009**. Physicians must determine medical eligibility for these injuries before an injured worker can receive vocational rehabilitation. This process is described in the Physician's Guide.

B. Job Displacement Benefits: This section applies to injuries occurring on or after 01-01-04. Physicians do not need to determine medical eligibility for these workers. Rather, if certain conditions (see below) are met, the benefits are automatic. They do not receive up to $16,000 for vocational rehabilitation. Instead, they can receive an educational voucher worth up to $10,000. The amount of the voucher is determined by the level of the disability rating.

1. Labor Code Section 4658.5 allows for educational vouchers up to $10,000.00.

1. Requirements:

    a. Injury causes permanent disability.

    b. If the injured employee does not return to work for 60 days after termination of temporary disability. The voucher is not dependent upon the physician finding the injured worker to be medically qualified for vocational rehabilitation.

    c. The benefit includes non-transferable vouchers for educational-related retraining or skill enhancement or both at state approved or accredited schools.

        1. Amounts are based on the level of disability and range from $4000 to $10,000.

        2. Vouchers may be used for payment of tuition, fees, books, and other expenses required by the school for retraining or skill enhancement.

        3. No more than 10% is to be used for vocational or return-to-work counseling.

X: Fraud: Labor Code 3823 reads as follows:

(b) Any insurer, self-insured employer, third-part administrator, workers' compensation administrative law judge, audit unit, attorney, or other person that believes that a fraudulent claim has been made by any person or entity providing medical care, as described in Section 4600, shall report the apparent fraudulent claim in the manner prescribed by subdivision (a).

(c) No insurer, self-insured employer, third-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person that reports any apparent fraudulent claim under this section shall be subject to any civil liability in a cause of action of any kind when the insurer, self-insured employer, third-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person acts in good faith, without malice, and reasonably believes that the action taken was warranted by the known facts, obtained by reasonable efforts. Nothing in this section is intended to, nor does in any manner, abrogate or lessen the existing common law or statutory privileges and immunities of any insurer, self-insured employer, third-party administrator, workers' compensation administrative law judge, audit unit, attorney, or other person.

List of Web Page Links to Resources

(Note: These online references are provided to supplement your study. You do <u>not</u> need to memorize statute or regulation names, titles or numbers. You will be tested on your general knowledge and understanding of the statutes and regulations that apply to the work of QMEs in the California workers' compensation system.)

California Constitution provisions on the California workers' compensation system - Article XIV, section 4: http://www.leginfo.ca.gov/.const/.article_14

Regulations governing QMEs and AMES:
(§§ 1 – 159 - complete in one Word or PDF document):
http://www.dir.ca.gov/dwc/DWCPropRegs/qme_regulations/qme_regulations.htm

(listed by article): http://www.dir.ca.gov/samples/search/querydwc.htm
(spinal surgery second opinion regulations-§§9788.01 – 9788.91):
http://www.dir.ca.gov/t8/ch4_5sb1a5_1.html
(How to serve your QME report on DEU and be EAMS compliant):
http://www.dir.ca.gov/dwc/MedicalUnit/QME_EAMSCompliant.pdf

California Labor Code (complete with table of contents):
http://www.leginfo.ca.gov/cgi-bin/calawquery?codesection=lab&codebody=&hits=20
Look up relevant Labor Code sections including:

§ 139.2 Apppointment, qualification, discipline of QMEs; timeframes, guidelines, procedures and admissibility of medical evaluations
§ 139.3- 139.31 Referral to person with whom physician has financial interest unlawful
§ 3209.3 Definition of "physician" under workers' compensation laws
§ 4600 Medical and Hospital treatment
§ 4604.5 Medical Treatment Utilization Schedule; presumption; limits on physical medicine treatments
§§ 4060 – 4062.2 Comprehensive medical-legal evaluations
§ 4062(b) – Disputes over recommended spinal surgery
§ 4061.5 Treating physician responsibilities
§ 4062.3 Information to AME and QME; *Ex Parte* communications
§ 4062.5 Failure of QME to complete timely evaluation
§ 4620 – 4626 Medical-legal expenses
§ 4628 Responsibilities of physician signing medical-legal report

<u>Forms used by QMEs and AMEs:</u>
(all current forms):
http://www.dir.ca.gov/dwc/DWCPropRegs/qme_regulations/qme_regulations.htm
[Note: **only** use versions listed near the top of this webpage, appearing between the black heading "Forms" and the black heading "Comment Chart".]

(select forms available in fillable format):
http://www.dir.ca.gov/dwc/forms.html
[Note: Scroll down to heading "Qualified medical evaluator (QME) and agreed medical evaluator (AME) forms]

Regulations and forms used by treating physicians:
http://www.dir.ca.gov/t8/ch4_5sb1.html

(Look on this page for articles or sections listed below):

Article 5; § 9785 – Reporting duties of treating physician
Article 5.1 – Spinal surgery second opinion procedures
Articles 5.3 and 5.5 - Official Medical Fee Schedule
Article 5.5.1 – Utilization review standards
Article 5.5.2; §§ 9792.20 – 9792.26 Medical Treatment Utilization Schedule
Article 5.6; §§ 9793 – 9795 Medical-Legal Expenses and Comprehensive Medical-Legal Evaluations
Article 5.7 – Fees for Interpreter Services

Doctor's First Reports (Requirements to file)

Labor Code 6409: http://www.leginfo.ca.gov/calaw.html
Regulation (8 Cal. Code Regs. 14003): http://www.dir.ca.gov/t8/14003.html
Form (pdf): http://www.dir.ca.gov/dlsr/dlsrform5021.pdf
Must file even for first aid (Labor Code § 6409(a)):
http://www.dir.ca.gov/dwc/firstaid.htm

Primary treating physician's Progress Report and Permanent and Stationary Report

PTP Progress Report ("PR-2"): http://www.dir.ca.gov/dwc/PR-2.pdf

PTP Permanent and Stationary Reports
1997 PD Rating Schedule ("PR-3"): http://www.dir.ca.gov/dwc/PR-3.pdf
2005 PD Rating Schedule ("PR-4"): http://www.dir.ca.gov/dwc/PR-4.pdf